healthfirst
Health Insurance for New Yorkers

Authorization to Release Protected Health Information (PHI) Instructions

Section 1 | Member Information

Be sure to fill this section out completely. For example, if you live in an apartment building, then include your apartment number. We will also need your Member ID to find you in our system.

Section 2 | The Purpose of this Authorization

Please indicate why you want us to release or share your information with this individual or entity.

Section 3 | Person or Entity that PHI Will Be Released to or Shared with

Write the full name of the person or entity you want us to release your information to or share it with. Please be specific; don't use general terms like "my daughter" or "my son." If you permit this person or entity to receive a hard copy of your records, we will need their address as well.

Please understand that if you would like us to share your information with more than one individual or entity, a separate form must be filled out for each individual or entity you would like us to share your information with.

Section 4 | Type of Information that Healthfirst is Authorized to Release or Share

4.1 Release My Protected Health Information

Complete this section if you would like to determine the specific type of information that you want Healthfirst to release to an authorized individual or entity.

Information being sent by email will be encrypted. To access your information, please follow the instructions in the email you receive.

4.2 Selecting a Personal Representative

Complete this section if you would like a personal representative to have continued access to your PHI and make certain changes and decisions on your behalf.

Section 5 | Expiration and Cancellation

Provide an expiration (end) date or describe the event that will make this authorization expire.
In no event will this authorization exceed twenty-four (24) months from the date the form is signed.

Section 6 | Important Information I Need To Know

It is important that you read the information in this section before signing this form.

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Section 7 | Member's or Authorized Party's Signature

Signature of Adult Member or Authorized Party

If you are the adult member or the authorized party signing this form, please check the applicable box to indicate your relationship to the member. Sign and print your name; don't forget to include the date.

Signature of Minor Members

If you are a minor signing this form, please check the applicable box. Sign and print your name; don't forget to include the date.

Please note that if you are the member signing this form, your name in this section must match the name used in Section 1.

If you are signing this form on behalf of the member, you must provide the supporting documentation authorizing you to represent the member.

Examples of supporting documentation (i.e., legal documentation):	
Power of Attorney	This legal document gives someone you trust permission to act on your behalf in healthcare billing/payment matters, which can include some health information. This individual cannot make healthcare decisions for you.
Executor of Estate	This legal document is used when the member is deceased and tasks an individual to handle the deceased member's estate/affairs.
Healthcare Proxy	This document gives someone you trust permission to make healthcare-related decisions if you are unable to make decisions or are incapacitated. **NOTE:** clinical documentation supporting the member's inability to make decisions must accompany the signed Healthcare Proxy form.
Guardianship	This court document gives a court-appointed individual authority to act on behalf of the member and to take care of the member, including property, healthcare, etc.

Return this completed form and any relevant documentation to

Healthfirst Member Services
Mail: P.O. Box 5165, New York, NY 10274-5165
Fax: 1-212-801-3250

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Authorization to Release Protected Health Information (PHI)

By completing or signing this form, I or my authorized party permit Healthfirst to share my PHI with the people or entities listed below. By Healthfirst, I also mean the company's subsidiaries, affiliates, employees, agents, and subcontractors. For help in completing this form, please read the instructions. Or contact Member Services at the phone number indicated on your Member ID card.

Section 1 | Member Information

First Name	Middle Initial	Last Name	
Member ID	Date of Birth (MM/DD/YYYY) _____/_____/_____	Phone Number	
Mailing Address	City	State	Zip Code

Section 2 | The Purpose of this Authorization

Please select or specify the reason for this authorization request.

☐ For My Use ☐ Other (please specify): _____

Section 3 | Person or Entity that PHI Will Be Released to or Shared with

Please check the box to indicate the person's or entity's relationship to you:

☐ Spouse ☐ Domestic Partner ☐ Adult Child ☐ Parent ☐ Other (please specify): _____

Please complete the following information:

Individual or Entity Full Name			
Mailing Address	City	State	Zip Code
Email	Phone Number		

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Section 4 | Type of Information that Healthfirst is Authorized to Release or Share

Select the option that applies and complete the section. If you are authorizing Healthfirst to release your PHI and select a personal representative, be sure to select and complete both sections below.

☐ 4.1 Release My Protected Health Information

Method of Disclosure: I want Healthfirst to release the following information by ☐ mail *or* ☐ email

Date of Service: from _____ through _____

Type of Information to be Released:

1. **Standard Health Information:** ☐ Claims and Related Appeals ☐ Billing/Enrollment
   ☐ Other (please specify): _____
2. **Sensitive Information** will **not** be released unless you specifically request it by checking the box and initialing in the space next to your selection:
   ☐ Mental Health _____ ☐ Sexually Transmitted Infections (STIs) _____
   ☐ HIV/AIDS _____ ☐ Reproductive Health/Family Planning Health _____
   ☐ All sensitive information _____

SUBSTANCE USE DISORDER (SUD): In order to comply with the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), the Authorization to Release Substance Use Disorder (SUD) Protected Health Information (PHI) form must be used to submit requests for SUD-related information.

☐ 4.2 Selecting a Personal Representative

Please identify the type of permission you are granting this personal representative (check all that apply):

☐ Make Primary Care Provider (or PCP) changes

☐ Discuss information related to my healthcare billing/payment matters

☐ Discuss information related to my diagnosis, treatment of illness/condition, or coverage. This may include talking to my care manager and being involved in the decision making with regards to my care

I understand this authorization will allow my authorized person to access my health information.

Section 5 | Expiration and Cancellation

This authorization will expire 24 (twenty-four) months from the date it is signed. Please insert a date or event that will make it expire.

☐ Authorization should expire on _____/_____/_____ (MM/DD/YYYY) or

☐ Once the following event occurs: _____

Right to Cancel: I may cancel this authorization form at any time. If I wish to do so, I can write to Healthfirst's Privacy Office either by mail to P.O. Box 5183, NY, NY 10274-5183, or by email at **HIPAAprivacy@healthfirst.org**. I understand it will not affect any action Healthfirst took before they received my cancellation request.

Section 6 | Important Information I Need To Know

My signature below means that I understand and agree to the following:

- This authorization is voluntary and can be cancelled at any time. My cancellation will not affect any action Healthfirst took before they received my cancellation request.
- With the exception of HIV/AIDS, my health information may be subject to re-disclosure by the recipient, and no longer protected by privacy regulations, if the organization or person authorized to receive the information is not a health plan or healthcare provider.
- Healthfirst cannot condition my treatment, payment, enrollment, or my eligibility for benefits and payment for services if I do not sign this form. However, without a valid form, my request to release information to the individual(s) or entity(ies) named above cannot be fulfilled.

Section 7 | Member's or Authorized Party's Signature

Select the section that applies and sign your name.

Adult Member's or Authorized Party's Signature
(Check the box that applies)

☐ You are the member, or the member's legal representative (please circle): Power of Attorney, Proxy, Guardianship, Other: _____

☐ You are the parent or legal guardian of a minor and the information shared does **not** pertain to one of the following "sensitive" conditions:

a. Mental Health

b. Sexually Transmitted Infections (STIs)

c. HIV/AIDS

d. Reproductive/Family Planning (including contraception, prenatal care, and abortion)

Signature _____

Print Name _____

Date _____

Minor Member's Signature
(check all applicable boxes)

☐ You are married

☐ You are not emancipated, between the ages of 12 and 17, and the information authorized for release pertains to one of the following sensitive conditions:

a. Mental Health

b. Sexually Transmitted Infections (STIs)

c. HIV/AIDS

d. Reproductive/Family Planning (including contraception, prenatal care, and abortion)

Signature _____

Print Name _____

Date _____

NOTE: If the person signing this authorization form is not the member, please provide the relevant document permitting you to act on the member's behalf (e.g., power of attorney, guardianship, executor of estate, etc.). Please see page 2 of the ***Authorization to Release Protected Health Information (PHI) Instructions*** **for examples of approved documentation.**

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